Virginia Cooperative Extension

4-H Health History Report Form *

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INSTRUCTIONS: Please provide detailed health information for determining appropriate supervision, support, and accommodations for the 4-H activity or event listed. **A parent or guardian must sign.** If the participant is a person with a disability and desires any assistive devices, services or other accommodations to participate in this activity, please contact your local Extension office during business hours at least 7 days prior to the event to discuss accommodations. **PLEASE PRINT ALL INFORMATION**. (NOTE: Both sides of this form must be completed.)

NAME OF 4-H EVENT IN WHICH YOU WISH TO PARTICIPATE: _____

DATE(S) OF EVENT: _____ LOCATION: _____

PARTICIPANT IDENTIFICATION

NAME: _____ FEMALE: ☐ MALE: ☐

Last *First* *(Underline name by which you like to be called)* *Middle*

MAILING ADDRESS: _____ PARTICIPANT CELL PHONE: (_____) _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: (_____) _____

AGE: _____ BIRTHDATE: _____ HOME EMAIL: _____

RACE: (Optional) WHITE ☐ HISPANIC ☐ BLACK ☐ AMERICAN INDIAN ☐ ASIAN ☐ MULTICULTURAL ☐

PARENT / GUARDIAN IDENTIFICATION (Place a check beside who to reach in the event of an emergency.)

❑ FATHER'S NAME (OR GUARDIAN): _____ FATHER'S EMAIL: _____

FATHER'S PHONE DAYTIME: _____ EVENING: _____ CELL: _____

❑ MOTHER'S NAME (OR GUARDIAN): _____ MOTHER'S EMAIL: _____

MOTHER'S PHONE DAYTIME: _____ EVENING: _____ CELL: _____

WHO HAS PRIMARY CUSTODY OF THE PARTICIPANT? _____

ADDRESS, IF DIFFERENT THAN CHILD: _____

PHYSICIAN / INSURANCE INFORMATION

FAMILY PHYSICIAN NAME: _____

PHONE: (_____) _____

DENTIST / ORTHODONTIST NAME: _____

PHONE: (_____) _____

DO YOU CARRY FAMILY MEDICAL / HOSPITAL INSURANCE?: **YES** ☐ **NO** ☐ (Check √ one)

CARRIER: _____

POLICY ID #: _____

EMERGENCY CONTACT INFORMATION (Parts 1 and 2 should be completed)

1. WHERE CAN YOU BE REACHED IN THE EVENT OF AN EMERGENCY?

   LOCATION: _____

   PHONE: (_____) _____

   CELL PHONE: (_____) _____

2. IF YOU **CANNOT** BE REACHED, WHO SHOULD BE NOTIFIED?

   NAME: _____

   HOME PHONE: (_____) _____

   WORK PHONE: (_____) _____

   CELL PHONE: (_____) _____

(continued on back)

4-H PARTICIPANT MEDIA RELEASE

The Virginia Polytechnic Institute and State University/College of Agriculture and Life Sciences (CALS) periodically uses electronic and traditional media (e.g., photographs, video, audio footage, testimonials) for publicity and educational purposes. By my signature on this form, I acknowledge receipt of this document and give permission to the College of Agriculture and Life Sciences and its designee to use such reproductions for educational and publicity purposes in perpetuity without further consideration from me.

I understand that I will need to notify Virginia Tech/College of Agriculture and Life Sciences if any changes to my situation occur that will impact this media release permission.

☐ **YES** ☐ **NO**

* 18 U.S.C. 707

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Virginia Tech 1872 *Invent the Future*

VIRGINIA STATE UNIVERSITY

PARTICIPANT HEALTH AND MEDICAL HISTORY

(Questions 1-5 must be completed.)

1. SPECIAL DIETARY NEEDS

INSTRUCTIONS: The purpose of this section is to communicate special dietary needs, food allergies, etc. for any child, teen, or adult who will be attending a 4-H event.

In the space below, please list all **food allergies and/or other dietary restrictions** for the person listed above and any necessary precautions that should be taken:

_____

_____

_____

_____

_____

_____

2. Has the participant ever experienced (or had special needs in) any of the following? [Check (✔) all that apply]

☐ Asthma	☐ Bleeding disorders	☐ Attention disorders (ADHD)
☐ Eating disorders	☐ Seizures/Convulsions	☐ Wears contacts
☐ Diabetes	☐ Bed Wetting	☐ Behavior
☐ Fainting spells	☐ Non-food allergies	☐ Other: _____

Please describe any condition or need that you checked:

_____

_____

_____

_____

_____

_____

3. Is the participant experiencing any current health problems, under medical care, receiving mental or behavioral services, or currently taking medication?

☐ YES ☐ NO If YES, *please explain:* _____

_____

4. Has the participant undergone surgery, or experienced any injury, illness, allergy, or change in health status any time during the last year? Is there any reason that participation in a program or activity should be restricted?

☐ YES ☐ NO If YES, *please explain:* _____

_____

5. What else should we know about your child?

4-H programs include very rewarding, but sometimes challenging situations. Please inform us of any concerns that may arise related to your child's physical, mental, emotional, and/or social health in order that we may better provide appropriate supervision and support.

_____

_____

_____

APPROVAL / EMERGENCY AUTHORIZATION

(Please read parts 1 and 2. If the participant is under 18, parents/guardians must sign in the space provided. If you are over the age of 18, please sign for yourself. If you cannot sign this due to religious reasons, you must contact your Extension office to obtain a legal waiver that must be signed. **If this section is not signed, participation in the 4-H event/activity will not be allowed.** You must contact your Extension office if there is a change in health status after submitting this form.

1. I give my permission for the participant named on this form to attend the designated 4-H program. He / She has permission to participate in all activities which may include swimming and other water sports under the supervision of lifeguard(s) and to take part in other scheduled activities such as firearm safety, horsemanship, archery, low ropes, physical activity/exercise and related activities under the supervision of instructors; subject to limitations noted herein.
2. I hereby give permission to the medical staff person selected by the event/activity director to order X-rays, routine tests and treatment for my child (or for myself if I am a participant over 18 years old) as medically necessary. I also give permission for the participant to receive over-the-counter medication as needed under the guidance of the medical staff person. I understand that all attempts will be made to notify parents/guardians of any serious injury or illness to their child. If I cannot be reached in an emergency, I hereby give permission to the medical staff person to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or the participant named on this form. This form may be photocopied for use outside of the event/activity location.

ADULT PRINTED NAME:

_____

SIGNED: **X**_____

(Parent / Legal Guardian or participant over 18 years old)

Date: _____

I understand and agree to abide with any restrictions placed on my activities according to this form.

YOUTH PRINTED NAME:

_____

SIGNED: **X**_____

(Participant under 18 years old)

Date: _____

IMMUNIZATION HISTORY (This must be completed)

Are your child's immunizations up to date? ☐ YES ☐ NO **Date of most recent tetanus shot:** (month/year) _____/_____

RELEASE AUTHORIZATION

I give permission to the following individual(s) to pick up my child at the conclusion of this 4-H event:

Name(s): _____, _____, _____

Sign below at time of pick up (Receiving person must be pre-listed above)**:**

Name (print): _____ Signature: _____ Date: _____